Appendix A

Enabling Legislation

HOUSE BILL 1274 (Chapter 318 of 2001)

Patients' Safety Act of 2001

Section 19-139 of the Health General Article

(A) The Commission, in consultation with the Department of Health and Mental Hygiene, shall study the feasibility of developing a system for reducing the incidences of preventable adverse medical events in the state including but not limited to a system of reporting such incidences.

(B) In conducting the study the Commission shall review:

(1) Federal reports and recommendations for identification of medical errors including the most recent report of the Institute of Medicine of the National Academy of Sciences;

(2) Recommendations of national accrediting and quality assurance organizations including the Joint Commission on the Accreditation of Health Care Organizations;

(3) Recommendations of the National Quality Forum:

(4) Programs in other states designed to reduce adverse medical events; and

(5) Best practices of hospitals and other health care facilities.

SECTION 2. And be it further enacted, that, on or before January 1, 2002, the Maryland Health Care Commission issue a preliminary report and, on or before January 1, 2003, issue a final report to the Governor and, subject to §2-1246 of the State Government Article, the House Economic Matters and House Environmental Matters committees, and the Senate Finance Committee on the Commission's recommendations as a result of the study required by this Act.

SECTION 3. And be it further enacted, that this Act shall take effect July 1, 2001.

Appendix B

States with Hospital Mandatory Reporting of Adverse Events

States with Hospital Mandatory Reporting of Adverse Events

California	New York
Colorado	Ohio
Connecticut	Pennsylvania
Florida	Rhode Island
Kansas	South Carolina
Massachusetts	South Dakota
Maine	Tennessee
Nebraska	Texas
Nevada	Utah
New Jersey	Washington

Appendix C

Joint Commission on Accreditation of Healthcare Organizations
National Patient Safety Goals

Joint Commission on Accreditation of Healthcare Organizations
2003 National Patient Safety Goals

1. Improve the accuracy of patient identification.
a. Use at least two patient identifiers (neither to be the patient's room number) whenever taking blood samples or administering medications or blood products.
b. Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active—not passive—communication techniques.

2. Improve the effectiveness of communication among caregivers.
a. Implement a process for taking verbal or telephone orders that requires a verification "read-back" of the complete order by the person receiving the order.
b. Standardize the abbreviations, acronyms and symbols used throughout the organization, including a list of abbreviations, acronyms and symbols not to use.

3. Improve the safety of using high-alert medications.
a. Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.
b. Standardize and limit the number of drug concentrations available in the organization.

4. Eliminate wrong-site, wrong-patient, wrong-procedure surgery.
a. Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.
b. Implement a process to mark the surgical site, and involve the patient in the marking process.

5. Improve the safety of using infusion pumps.
a. Ensure free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization.

6. Improve the effectiveness of clinical alarm systems.
a. Implement regular preventive maintenance and testing of alarm systems.
b. Assure that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit.

(Source: Joint Commission on Accreditation of Healthcare Organizations, 2003 National Patient Safety Goals, http://www.jcaho.org/accredited+organizations/patient+safety/npsg/npsg_03.htm)

Appendix D

Congressional Action

PATIENT SAFETY RELATED BILLS
INTRODUCED IN THE
106TH AND 107TH CONGRESS

106TH CONGRESS (1999-2000)	107TH CONGRESS (2001-2002)
S. 2038 – Specter "Medical Error Reduction Act of 2000" Introduced: February 8, 2000 Status: referred to Senate subcommittee Summary: Amends the Public Health Service Act to require the Secretary of HHS to make grants to States to establish reporting systems to reduce medical errors	S. 3029 – Kennedy "Patient Safety Improvement and Medical Injury Reduction Act" Introduced: October 2, 2002 Status: Referred to House Subcommittee Summary: Amends the Public Health Service Act to make privileged and confidential patient safety information. Grants protections against adverse employment actions to individuals who report certain information to providers or patient safety organizations. Directs the Secretary of HHS to award grants to eligible entities to promote community partnerships for health care improvement among providers. Requires the Secretary to develop voluntary, national standards that promote interoperability of health care information technology systems across all health care settings; and to make grants for CPOE, informatics systems, and patient safety research.
S. 2743 – Kennedy, Dodd, Murray "Voluntary Error Reduction and Improvement in Patient Safety Act" Introduced: June 15, 2000 Status: Referred to Senate subcommittee Summary: Amends the Public Health Service Act to develop an infrastructure for creating a national voluntary reporting system, prohibits a health care organization from discharging a worker for reporting	S. 2590 – Jeffords, Breaux, Frist, Gregg "Patient Safety and Quality Improvement Act" Introduced: June 5, 2002 Status: Referred to House subcommittee Summary: Amends the Public Health Service Act to make patient safety data privileged and confidential. Authorizes the establishment and maintenance of a database for non-identifiable patient safety data. Requires the Secretary of HHS to report to Congress on a study assessing the impact of medical technologies and therapies on patient safety and benefit, health care quality and costs, and productivity growth.
S. 2738 – Jeffords, Frist, Enzi "Patient Safety and Errors Reduction Act" Introduced: June 15, 2000 Status: referred to Senate subcommittee Summary: Amends the Public Health Service Act to authorize appropriations AHRQ for developing research to determine the causes of medical errors, to develop strategies to reduce them	S. 1686 – Kennedy, Kerry, Reid, Clinton "Safe Nursing and Patient Care Act of 2001" Introduced: November 14, 2001 Status: referred to Senate subcommittee Summary: Amends the Social Security Act to provide limitations to the number of hours a nurse is required to work mandatory overtime

S. 966 – Reid "Patient Safety Act of 1999" Introduced: May 5, 1999 Status: referred to Senate subcommittee Summary: Requires Medicare providers to disclose publicly, staffing and performance in order to promote consumer information and choice	S. 1594 – Clinton, Smith, Kennedy, Murray "Nurse Retention and Quality of Care Act of 2001" Introduced: October 30, 2001 Status: referred to Senate subcommittee Summary: Amends the Public Health Service Act to provide programs to improve nurse retention
H.R. 1288 – Hinchey, Capps, Nadler, Filner, Holden, Bishop, McCarthy, Olver, Serrano, Latourette, Kind, Defazio and Clyburn "Patient Safety Act of 1999" Introduced: March 25, 1999 Status: referred to House subcommittee Summary: Requires Medicare providers to disclose publicly staffing and performance in order to promote improved consumer information	S. 824 – Graham and Snowe " Medication Errors Reduction Act of 2001" Introduced: May 3, 2001 Status: referred to Senate subcommittee Summary: Directs the Secretary of HHS to establish a program to make grants to eligible entities for the purpose of assisting entities to offset the cost of purchasing, leasing, developing and implementing health care informatics systems
H.R. 3672 – Morella "Medication Error Prevention Act of 2000" Introduced: February 16, 2000 Status: referred to House subcommittee Summary: Amends Public Health Service Act to medication error information privileged for Federal and State administrative proceedings	S. 863 – Reid "Patient Safety Act of 2001" Introduced: May 10, 2001 Status: referred to Senate subcommittee Summary: Requires the Secretary of HHS to make public information regarding patient staffing and patient outcomes
	S. 705 – Shumer "Health Information Technology and Quality Improvement Act of 2001" Introduced: April 5, 2001 Status: referred to Senate subcommittee Summary: provides grant program to hospitals, skilled nursing facilities and home health agencies for the establishment of information technology and requires that HHS reimburse these entities for IT systems costs
	H.R. 4889 – Johnson, Camp, English, Fletcher, Herger, Hayworth, Houghton, Lewis, Morella, Portman, Smith, Thomas, Weller "Patient Safety and Quality Improvement Act of 2002" Introduced: June 6, 2002 Status: Passed out of Committee and is under reconciliation with H.R. 5478 Summary: Amends the Social Security Act to provide for a voluntary reporting to the Secretary of HHS. Confidentiality and peer review

	protections provided. Establishes patient safety organizations in the states to collect and analyze data and a national patient safety database to collect, support, and coordinate the analysis of the reported data. Requires the Secretary to develop voluntary, national standards that promote the interoperability of health care information technology systems and encourage health care providers to adopt evidence-based practices. Creates a Medical Information Technology Board.
	H.R. 5478 – Bilirakis, Barrett, Brown, Boucher, Burr, DeGette, Deutsch, Dingell, Doyle, Engel, Ganske, Green, Greenwood, Harman, John, McCarthy, Norwood, Pallone, Rush, Sawyer, Tauzin, Terry, Towns, Upton, Waxman, Whitfield, Wynn "Patient Safety and Quality Improvement Act" Introduced: September 26, 2002 Status: Passed out of Committee and is under reconciliation with H.R. 4889 Summary: Amends the Public Health Service Act to make "patient safety work product" (reported information) privileged information. Creates Patient Safety Organizations to collect and analyze patient safety work products; develop and disseminate evidence-based information to providers; and maintain confidentiality protections. Requires the Secretary to establish and maintain a national database to collect and analyze data submitted to PSOs to identify trends and patterns of health care errors. Requires the Secretary to develop or adopt voluntary national standards promoting the interoperability of information technology systems involved with health care delivery. Authorizes the Secretary to make grants to practitioners for electronic prescription programs. Directs the Secretary to make grants to hospitals and other health care providers for information technologies, and to provide technical assistance to applicants and grantees. Sets forth a matching requirement for the grants of not less than 50 percent of the costs.
	H.R. 2340 – Foley, Baldacci, Bonior, Carson (B), Carson (J), Cummings, Frost, Kleszka, McGovern, Miller, Norton, Pelosi, Rush, Sandlin,

	Schakowsky, Serrano, Stark, Wexler "Patient Safety and Health Care Whistleblower Protection Act of 2001" Introduced: June 27, 2001 Status: Referred to House subcommittees Summary: Prohibits retaliation or discrimination against a health care worker for disclosing information, advocating for patients, or involvement with a governmental proceeding.
	H.R. 5269 – Baldwin "Health Care Security for All Americans Act" Introduced: July 26, 2002 Status: referred to House subcommittee Summary: provides funding to States for universal health insurance coverage through State administered systems. Establishes a Health Care Quality, Patient Safety, and Workforce Standards Institute within the Agency for Healthcare Research and Quality.
	H.R. 3238 – Stark, Latourette, Rangel, Barrett, Kleczka, Pomeroy, Lewis, Waxman, Coyne, Schakowsky, etc. "Safe Nursing & Patient Care Act of 2001" Introduced: November 6, 2001 Status: referred to House subcommittee Summary: limits the number of hours a nurse is required to work mandatory overtime
	H.R. 1804 – Hinchey "Patient Safety Act of 2001" Introduced: May 10, 2001 Status: referred to House subcommittee Summary: Requires that providers under Medicare make publicly available nurse staffing and patient outcomes
	H.R. 3292 – Houghton "Medication Errors Reduction Act of 2001" Introduced: November 14, 2001 Status: referred to House subcommittees Summary: Establishes an informatics grant program to hospitals and skilled nursing facilities to encourage facilities to make major information technology upgrades and develop a Medical Technology Advisory Board
	H.R. 2173 – McGovern "Pharmacy Education Aid Act of 2001"

	Introduced: June 14, 2001 Status: referred to House subcommittee Summary: Includes Pharmacists within the list of national health service corps program

(Source: THOMAS - Legislative Information on the Internet, The Library of Congress, http://thomas.loc.gov)

Appendix E

National Quality Forum's
Serious Reportable Adverse Events

National Quality Forum's List of Serious Reportable Adverse Events

Event	Additional Specifications
1. SURGICAL EVENTS	
A. Surgery performed on the wrong body part	Defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent.
B. Surgery performed on the wrong patient	Defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.
C. Wrong surgical procedure performed on a patient	Defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent.
D. Retention of a foreign object in a patient after surgery or other procedure	Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.
E. Intraoperative or immediately post-operative death in an ASA Class I patient	Includes all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out. Immediately post-operative means within 24 hours after induction of anesthesia (if surgery not completed), surgery, or other invasive procedure was completed.
2. PRODUCT OR DEVICE EVENTS	
A. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility	Includes generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination and/or Product
B. Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended. .	Includes, but is not limited to, catheters, drains and other specialized tubes, infusion pumps, and ventilators
C. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility	Excludes deaths associated with neurosurgical procedures known to be a high risk of intravascular air embolism.

3. PATIENT PROTECTION EVENTS	
A. Infant discharged to the wrong person	Excludes events involving competent adults.
B. Patient death or serious disability associated with patient elopement (disappearance) for more than four hours	
C. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility	Defined as events that result from patient actions after admission to a healthcare facility. Excludes deaths resulting from self-inflicted injuries that were the reason for admission to the healthcare facility
4. CARE MANAGEMENT EVENTS	
A. Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)	Excludes reasonable differences in clinical judgment on drug selection and dose.
B. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products	
C. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility	Includes events that occur within 42 days post-delivery. Excludes deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy or cardiomyopathy.
D. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility	
E. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinimia in neonates	Hyperbilirubinimia is defined as bilirubin levels >30 mg/dl. Neonates refer to the first 28 days of life.
F. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility	Excludes progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
G. Patient death or serious disability due to spinal manipulative therapy	

5. ENVIRONMENTAL EVENTS	
A. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility	Excludes events involving planned treatments such as electric countershock.
B. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances	
C. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility	
D. Patient death associated with a fall while being cared for in a healthcare facility	
E. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility	
1. CRIMINAL EVENTS	
A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed healthcare provider	
B. Abduction of a patient of any age	
C. Sexual assault on a patient within or on the grounds of the healthcare facility	
D. Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the healthcare facility	

(Abstracted from The National Quality Forum, "Serious Reportable Events in Patient Safety: A National Quality Forum Consensus Report," http://www.qualityforum.org)

Appendix F

Maryland Patient Safety Coalition
Subcommittee on the Creation of a Patient Safety Center

List of Participants

Maryland Patient Safety Coalition
Subcommittee on the Creation of a Patient Safety Center

List of Participants

Co-Chairs:
Barb McLean, Executive Director, Maryland Health Care Commission (MHCC)
T. Michael Preston, Executive Director, MedChi

Howard Schiff, Executive Director, Maryland Pharmacists Association

Debra Bittle, MS, CPHRM, Upper Chesapeake Medical Center

Donna Dorsey, Executive Director, Maryland Board of Nursing

Marie McBee, Vice President for Federal Programs, The Delmarva Foundation

Carol Benner, Director, Office of Health Care Quality, Maryland Department of Health and Mental Hygiene (DHMH),

Enrique Martinez-Vidal, Deputy Director for Performance & Benefits, MHCC

Kristin Helfer Koester, Chief of Legislative and Special Projects, MHCC

Appendix G

Maryland Patient Safety Coalition
Subcommittee on Systems Improvements

List of Participants

Maryland Patient Safety Coalition
Subcommittee on Systems Improvements

List of Participants

Chair:
Enrique Martinez-Vidal, Deputy Director for Performance & Benefits, Maryland Health Care Commission (MHCC)

Steven S. Cohen, MedStar Health

Kathleen White, PhD, RN, Director of Faculty Practice School of Nursing, The Johns Hopkins University

Beverly Miller, Senior Vice President, Professional Activities, The Association of Maryland Hospitals & Health Systems (MHA)

Shawn Becker, Director, Patient Safety Initiatives, U.S. Pharmacopeia

Susan H. Longley, RN, BSN, JD, Maryland General Hospital

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William F. Minogue, M.D., Suburban Hospital Healthcare System

Marie McBee, MSN, Vice President, Delmarva Foundation

Linda E. Jones, Senior Vice President, Riggs, Councilman, Michaels, & Downs (RCM&D)

Jeanne Furman, Commissioner, Maryland Board of Pharmacy

Howard Schiff, Executive Director, Maryland Pharmacists Association

Barbara McLean, Executive Director, MHCC

Kristin Helfer Koester, Chief of Legislative and Special Projects, MHCC

Appendix H

Maryland Patient Safety Coalition
Subcommittee on Patient Safety Regulations

List of Participants

Maryland Patient Safety Coalition
Subcommittee on Patient Safety Regulations

List of Participants

Chair:
Carol Benner, Director, Office of Health Care Quality, Maryland Department of Health and Mental Hygiene (DHMH)

Linda Masterson, Office of Health Care Quality, DHMH

Renee Webster, Office of Health Care Quality, DHMH

Beverly Miller, Senior Vice President, Professional Activities, The Association of Maryland Hospitals & Health Systems (MHA)

Pegeen Townsend, Senior Vice President, Legislative Policy, MHA

Vahe Kazandijian, Senior Vice President, MHA

Nancy Barczak, University of Maryland Medical System

Jane McConnell, University of Maryland Medical System

Kathy Hale, The Johns Hopkins University Health System

Sheila Higdon, Government Relations Coordinator, Johns Hopkins Medicine

Maggie Miller, Johns Hopkins Bayview Medical Center

Debra Bittle, MS, CPHRM, Upper Chesapeake Medical Center

Craig Juengling, Potomac Ridge Behavioral Health, Adventist HealthCare, Inc.

Barbara Hirsch, Washington Adventist Hospital

Anne Flood, Union Memorial Hospital

Ellen Barton, President of Maryland Society for Hospital Risk Managers

Rick Kidwell, The Johns Hopkins University Health System

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Linda E. Jones, Senior Vice President, Riggs, Councilman, Michaels, & Downs (RCM&D)

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Kristin Helfer Koester, Chief of Legislative and Special Projects, MHCC

Appendix I

Agency for Healthcare Research and Quality Patient Safety Evidence-based Practices

Agency for Healthcare Research and Quality
Patient Safety Evidence-based Practices

Listed below are 11 patient safety practices that were considered by the Evidence-based Practice Center at the University of California/Sanford University as "highly proven to work but are not performed routinely in the nation's hospitals and nursing homes."[1]

- Appropriate use of prophylaxis to prevent venous thromboembolism in patients at risk.
- Use of perioperative beta-blockers in appropriate patients to prevent perioperative morbidity and mortality.
- Use of maximum sterile barriers while placing central intravenous catheters to prevent infections.
- Appropriate use of antibiotic prophylaxis in surgical patients to prevent postoperative infections.
- Asking that patients recall and restate what they have been told during the informed consent process.
- Continuous aspiration of subglottic secretions (CASS) to prevent ventilator-associated pneumonia.
- Use of pressure relieving bedding materials to prevent pressure ulcers.
- Use of real-time ultrasound guidance during central line insertion to prevent complications.
- Patient self-management for warfarin (Coumadin™) to achieve appropriate outpatient anticoagulation and prevent complications.
- Appropriate provision of nutrition, with a particular emphasis on early enteral nutrition in critically ill and surgical patients.
- Use of antibiotic-impregnated central venous catheters to prevent catheter-related infections.

[1] Agency for Health Care Research and Quality. "AHRQ Releases New Evidence on Proven Patient Safety Practices." http://www.ahrq.gov/news/press/pr2001/ptsafpr.htm.

Appendix J

Agency for Healthcare Research and Quality (AHRQ)
Patient Fact Sheet
20 Tips to Help Prevent Medical Errors

Agency for Healthcare Research and Quality (AHRQ)
Patient Fact Sheet
20 Tips to Help Prevent Medical Errors

Medical errors are one of the Nation's leading causes of death and injury. A recent report by the Institute of Medicine estimates that as many as 44,000 to 98,000 people die in U.S. hospitals each year as the result of medical errors. This means that more people die from medical errors than from motor vehicle accidents, breast cancer, or AIDS.

Government agencies, purchasers of group health care, and health care providers are working together to make the U.S. health care system safer for patients and the public. This fact sheet tells what you can do.

What are Medical Errors?

Medical errors happen when something that was planned as a part of medical care doesn't work out, or when the wrong plan was used in the first place. Medical errors can occur anywhere in the health care system:

- Hospitals.
- Clinics.
- Outpatient Surgery Centers.
- Doctors' Offices.
- Nursing Homes.
- Pharmacies.
- Patients' Homes.

Errors can involve: Medicines; Surgery; Diagnosis; Equipment; and Lab reports.

They can happen during even the most routine tasks, such as when a hospital patient on a salt-free diet is given a high-salt meal.

Most errors result from problems created by today's complex health care system. But errors also happen when doctors and their patients have problems communicating. For example, a recent study supported by the Agency for Healthcare Research and Quality (AHRQ) found that doctors often do not do enough to help their patients make informed decisions. Uninvolved and uninformed patients are less likely to accept the doctor's choice of treatment and less likely to do what they need to do to make the treatment work.

What Can You Do? Be Involved in Your Health Care

1. The single most important way you can help to prevent errors is to be an active member of your health care team.

That means taking part in every decision about your health care. Research shows that patients who are more involved with their care tend to get better results. Some specific tips, based on the latest scientific evidence about what works best, follow.

Medicines

2. Make sure that all of your doctors know about everything you are taking. This includes prescription and over-the-counter medicines, and dietary supplements such as vitamins and herbs.
At least once a year, bring all of your medicines and supplements with you to your doctor. "Brown bagging" your medicines can help you and your doctor talk about them and find out if there are any problems. It can also help your doctor keep your records up to date, which can help you get better quality care.

3. Make sure your doctor knows about any allergies and adverse reactions you have had to medicines.
This can help you avoid getting a medicine that can harm you.

4. When your doctor writes you a prescription, make sure you can read it.
If you can't read your doctor's handwriting, your pharmacist might not be able to either.

5. Ask for information about your medicines in terms you can understand—both when your medicines are prescribed and when you receive them.
- What is the medicine for?
- How am I supposed to take it, and for how long?
- What side effects are likely? What do I do if they occur?
- Is this medicine safe to take with other medicines or dietary supplements I am taking?
- What food, drink, or activities should I avoid while taking this medicine?

6. When you pick up your medicine from the pharmacy, ask: Is this the medicine that my doctor prescribed?
A study by the Massachusetts College of Pharmacy and Allied Health Sciences found that 88 percent of medicine errors involved the wrong drug or the wrong dose.

7. If you have any questions about the directions on your medicine labels, ask.
Medicine labels can be hard to understand. For example, ask if "four doses daily" means taking a dose every 6 hours around the clock or just during regular waking hours.

8. Ask your pharmacist for the best device to measure your liquid medicine. Also, ask questions if you're not sure how to use it.
Research shows that many people do not understand the right way to measure liquid medicines. For example, many use household teaspoons, which often do not hold a true teaspoon of liquid. Special devices, like marked syringes, help people to measure the right dose. Being told how to use the devices helps even more.

9. Ask for written information about the side effects your medicine could cause.
If you know what might happen, you will be better prepared if it does—or, if something unexpected happens instead. That way, you can report the problem right away and get help before it gets worse. A study found that written information about medicines can help patients recognize problem side effects and then give that information to their doctor or pharmacist.

Hospital Stays

10. If you have a choice, choose a hospital at which many patients have the procedure or surgery you need.
Research shows that patients tend to have better results when they are treated in hospitals that have a great deal of experience with their condition.

11. If you are in a hospital, consider asking all health care workers who have direct contact with you whether they have washed their hands.
Handwashing is an important way to prevent the spread of infections in hospitals. Yet, it is not done regularly or thoroughly enough. A recent study found that when patients checked whether health care workers washed their hands, the workers washed their hands more often and used more soap.

12. When you are being discharged from the hospital, ask your doctor to explain the treatment plan you will use at home.
This includes learning about your medicines and finding out when you can get back to your regular activities. Research shows that at discharge time, doctors think their patients understand more than they really do about what they should or should not do when they return home.

Surgery

13. If you are having surgery, make sure that you, your doctor, and your surgeon all agree and are clear on exactly what will be done.
Doing surgery at the wrong site (for example, operating on the left knee instead of the right) is rare. But even once is too often. The good news is that wrong-site surgery is 100 percent preventable. The American Academy of Orthopaedic Surgeons urges its members to sign their initials directly on the site to be operated on before the surgery.

Other Steps You Can Take

14. Speak up if you have questions or concerns.
You have a right to question anyone who is involved with your care.

15. Make sure that someone, such as your personal doctor, is in charge of your care.
This is especially important if you have many health problems or are in a hospital.

16. Make sure that all health professionals involved in your care have important health information about you.
Do not assume that everyone knows everything they need to.

17. Ask a family member or friend to be there with you and to be your advocate (someone who can help get things done and speak up for you if you can't).
Even if you think you don't need help now, you might need it later.

18. Know that "more" is not always better.
It is a good idea to find out why a test or treatment is needed and how it can help you. You could be better off without it.

19. If you have a test, don't assume that no news is good news.
Ask about the results.

20. Learn about your condition and treatments by asking your doctor and nurse and by using other reliable sources.
For example, treatment recommendations based on the latest scientific evidence are available from the National Guidelines Clearinghouse at http://www.guideline.gov. Ask your doctor if your treatment is based on the latest evidence.

A Federal report on medical errors can be accessed online, and a print copy (Publication No. OM 00-0004) is available from the AHRQ Publications Clearinghouse: phone, 1-800-358-9295 (outside the United States, please call 410-381-3150) or E-mail: ahrqpubs@ahrq.gov. *AHRQ Publication No. 00-PO38. Current as of February 2000*